BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
	Case No: 18-1999-101122
ANDREW RUTLAND, M.D.	
Physician's and Surgeon's Certificate #G-24947	
Respondent.	

DECISION AND ORDER

The attached Stipulation for Surrender of Physician and Surgeon's Certificate and Physician Assistant Supervisor License is hereby accepted and adopted as the Decision and Order by the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on October 24, 2002.

IT IS SO ORDERED September 24, 2002

MEDICAL BOARD OF CALIFORNIA

Steven Rubins, M.D.
Panel B
Division of Medical Quality

BILL LOCKYER, Attorney General
of the State of California
D. KENNETH BAUMGARTEN
Deputy Attorney General
State Bar No. 124371
California Department of Justice
110 West A Street, Suite 1100
Post Office Box 85266
San Diego, California 92816-5266
Telephone: (619) 645-2195
Facsimile: (619) 645-2061

Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ANDREW RUTLAND, M.D.** 7495 Hummingbird Circle Anaheim Hills, CA 90807 Physician and Surgeon's Certificate No. G 24947 Physician Assistant Supervisor License No. SA 18870 Respondent.	CASE NO. 18-1999-101122 OAH NO. L-2002070042 **STIPULATION FOR SURRENDER OF PHYSICIAN and SURGEON'S CERTIFICATE NO. G 24947 and PHYSICIAN ASSISTANT SUPERVISOR LICENSE NO. SA 18870**

IT IS HEREBY STIPULATED AND AGREED, by and between the parties to the above-entitled proceedings, that the following matters are true:

1. Complainant, Ron Joseph, is the Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board") and is represented by Bill Lockyer, Attorney General of the State of California by D. Kenneth Baumgarten, Deputy Attorney General.

2. Respondent, Andrew Rutland, M.D., is represented by Mr. Peter R. Osinoff, Esq., of Bonne, Bridges, Mueller, O'Keefe & Nichols, 3699 Wilshire Blvd., 10th Floor, Los Angeles, CA 90010-2719; (213) 738-5838.

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3. Respondent has received and read the Third Amended Accusation in this matter, filed June 28, 2002, which is the culmination of multiple Medical Board investigations reflecting the following case numbers: 18-1999-101122;18-2000-112939;18-2000-117679; 18-2000-114677; 18-2000-114683; 18-2000-116414; 18-2000-114224; 18-2000-114700; 18-2000-112937; 18-2000-114678; 18-2000-115566; 18-2002-134646 (M.A.); 18-2002-134650 (BJG); 18-2002-134651 (VG); 18-2002-134647 (J.W.); 18-2002-134903 (Medical Record No. 365409).

This Third Amended Accusation is presently on file and pending before the Board and the Division of Medical Quality, hereinafter "Division", a copy of which is attached hereto as **Exhibit A** and is incorporated herein by reference.

4. On July 3, 2002, an full Interim Suspension Order was issued by the Office of Administrative Hearings in Los Angeles suspending Respondent from the practice of medicine in California pending a disciplinary hearing on the charges in the Third Amended Accusation. This Interim Suspension Order is presently on file with the Board and the Division, a copy of which is attached hereto as **Exhibit B** and is incorporated herein by reference.

5. Respondent understands the nature of the charges alleged in the Third Amended Accusation and that, if proven at hearing, such charges and allegations would constitute cause for imposing discipline upon Respondent's license issued by the Board.

6. Respondent is aware of each of his rights, including the right to a hearing on the charges and allegations; the right to be represented by counsel at his own expense; the right to confront and cross-examine witnesses who would testify against Respondent; the right to testify and present evidence on his own behalf, as well as to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to contest the charges and allegations; and other rights which are accorded Respondent pursuant to the California Administrative Procedure Act (Gov. Code, § 11500 et seq.) and other applicable laws, including the right to seek reconsideration, review by the superior court, and appellate review.

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7. Respondent, having discussed this matter with his counsel, freely and voluntarily waives each and every one of the rights set forth in paragraph 6.

8. For the purpose of resolving the Third Amended Accusation, Respondent hereby admits to the charges involving the Broussard matter, also known as "K.B.", as set forth in paragraphs 12 (except sub-paragraphs Q and R) and 13 (except sub-paragraphs K and O) of the Third Amended Accusation. Further, Respondent agrees that, at a hearing, Complainant could also establish a factual basis for the one or more of the other charges in the Third Amended Accusation. Respondent hereby gives up his right to contest these charges.

9. Respondent understands that by signing this Stipulation, he is enabling the Division to issue its Order accepting the surrender of his licenses without further process. It is also understood by Respondent that, in deciding whether to adopt this Stipulation, the Division may receive oral and written communications from its staff and the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Division or other persons from future participation in this or any other matter affecting Respondent. In the event this Stipulation is not adopted by the Division, this Stipulation will not become effective and may not be used for any other purpose, except for this paragraph, which shall remain in effect.

10. Upon acceptance of this Stipulation by the Division, Respondent agrees to cause to be delivered to the Division, both his wall and wallet certificates before the effective date of the Decision. Respondent further understands that, on or after the effective date of this Decision, he will no longer be permitted to practice as a physician and surgeon in California.

PAY CURRENT DISCOVERY COSTS

11. Upon acceptance of this Stipulation by the Division, Respondent agrees to pay to the Board the sum of $3160.00 (three thousand, one hundred and sixty dollars) which represents partial reimbursement for costs incurred in providing document discovery to Respondent during this disciplinary action to date.

Respondent shall pay the $3160.00 on or before the expiration of the 30 day period preceding the effective date of the Decision by the Division in this matter. Should

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Respondent fail to pay this amount when due. then he shall not be entitled to petition the Board for reinstatement until the $3160.00 is paid in full.

COST RECOVERY

12. Upon acceptance of this Stipulation by the Division, Respondent agrees that if and/or when he ever meets the requirements by the California Medical Board for reinstatement of his medical certificate, that after filing a petition for reinstatement, and prior to re-issuance of a license, Respondent shall pay the sum of $37,000.00 (thirty-seven thousand dollars) which represents a portion of the cost recovery to which Complainant is entitled in this matter.

CONTINGENCY

This Stipulation shall be subject to the approval of the Division of Medical Quality. Respondent understands and agrees that Board staff and counsel for Complainant may communicate directly with the Division regarding this Stipulation for Surrender, without notice to or participation by Respondent or his counsel.

If the Division fails to adopt this Stipulation as its Order, the Stipulation shall be of no force or effect, it shall be inadmissible in any legal action between the parties, and the Division shall not be disqualified from further action in this matter by virtue of its consideration of this Stipulation.

ACCEPTANCE

I have read the above Stipulation for Surrender and have fully discussed this Stipulation and other related matters contained therein with my attorneys. I understand the effect this Stipulation for Surrender will have on my Physician and Surgeon's Certificate, and agree to be bound thereby. I enter this Stipulation freely, knowingly, intelligently and voluntarily.

DATED: 25 Aug 02

Andrew Rutland MD

ANDREW RUTLAND, M.D.
Respondent

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I have read and have fully discussed the terms and other matters contained in this Stipulation for Surrender with Respondent, Andrew Rutland, M.D., and approve of its form and content.

DATED: 8/26/02

PETER R. OSINOFF, Esq.
Bonne, Bridges, Mueller, O'Keefe & Nichols
Attorneys for Respondent

ENDORSEMENT

The foregoing Stipulation for Surrender is hereby respectfully submitted for consideration by the Division of Medical Quality, Medical Board of California, Department of Consumer Affairs.

DATED: August 26, 2002

BILL LOCKYER, Attorney General
of the State of California

D. KENNETH BAUMGARTEN
Deputy Attorney General
Attorneys for Complainant

Exhibit A: Third Amended Accusation No. 18-1999-101122

Exhibit B: Interim Suspension Order, dated July 3, 2002

EXHIBIT A
THIRD AMENDED ACCUSATION
NO. 18-1999-101122

BILL LOCKYER, Attorney General
of the State of California
D. KENNETH BAUMGARTEN, State Bar No. 124371
Deputy Attorney General
California Department of Justice
110 West "A" Street, Suite 1100
San Diego, California 92101

P.O. Box 85266
San Diego, California 92186-5266
Telephone: (619) 645-2195
Facsimile: (619) 645-2061

Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: ANDREW RUTLAND, M.D. 7495 Hummingbird Circle Anaheim Hills, California 90807 Physician's and Surgeon's Certificate No. G 24947 Physician Assistant Supervisor License No. SA 18870 **Respondent.**	Case Nos. 18-1999-101122; 18-2000-112939; 18-2000-117679; 18-2000-114677; 18-2000-114683; 18-2000-116414; 18-2000-114224; 18-2000-114700; 18-2000-112937; 18-2000-114678; 18-2000-115566; 18-2002-134646 (M.A.); 18-2002-134650 (BJG); 18-2002-134651 (VG); 18-2002-134647 (JW); 18-2002-134903 (Medical Record No.365409) **THIRD AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Ron Joseph ("Complainant") brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

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JURISDICTION

2. This Accusation is brought before the Division of Medical Quality, Medical Board of California ("Division"), under the authority of the following sections of the Business and Professions Code ("Code").

3. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Division deems proper.

4. Section 2234 of the Code states:

"The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

"(c) Repeated negligent acts.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate."

5. Section 125.3 of the Code provides, in pertinent part, that the Division may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

6. Section 14124.12 of the Welfare and Institutions Code states, in pertinent part:

> "(a) Upon receipt of written notice from the Medical Board of California, the Osteopathic Medical Board of California, or the Board of Dental Examiners of California, that a licensee's license has been placed on probation as a result of a disciplinary action, the department may not reimburse any Medi-Cal claim for the type of surgical service or invasive procedure that gave rise to the probation, including any dental surgery or invasive procedure, that was performed by the licensee on or after the effective date of probation and until the termination of all probationary terms and conditions or until the probationary period has ended, whichever occurs first. This section shall apply except in any case in which the relevant licensing board determines that compelling circumstances warrant the continued reimbursement during the probationary period of any Medi-Cal claim, including any claim for dental services, as so described. In such a case, the department shall continue to reimburse the licensee for all procedures, except for those invasive or surgical procedures for which the licensee was placed on probation."

7. Section 2261 of the Code states:

> "Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

8. Section 2262 of the Code states:

> "Altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct.
>
> "In addition to any other disciplinary action, the Division of Medical Quality or the California Board of Podiatric Medicine may impose a civil penalty of five hundred dollars ($500) for a violation of this section."

9. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

10. Section 725 of Code provides that excessive prescribing or administering of drugs or treatment is unprofessional conduct.

11. Section 726 of the Code provides that: " The commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct . . ."

THE OBSTETRICAL PATIENTS

FIRST CAUSE FOR DISCIPLINE

(Gross negligence, repeated negligent acts, incompetence)

PATIENT K.B.

12. Respondent is subject to disciplinary action under section 2234 of the Code in that he was grossly negligent, incompetent, and/or committed repeated negligent acts in his care and treatment of patients K.B., T.H., and Medical Record No. 365409. The circumstances are as follows:

A. On or about July 22, 1999, K.B. went to the Labor and Delivery Unit of the Martin Luther Hospital to have her first baby. She was 33-years-old at the time. She had a history of congenital neurogenic bladder[1], and had two operations as a child for this condition. She had been a patient of respondent's since about June 1999.

B. K.B. had spontaneous rupture of her membranes when she came to the hospital at about 2:50 a.m. on July 22, 1999.

C. Respondent made an admitting note at about 9:00 a.m. on July 22, 1999, and noted his plan to assist labor with Pitocin. K.B. was dilated about 1-2 cm. with the vertex at 0 station, and she had variable decelerations with her contractions.

D. K.B. received an epidural at about 11:00 a.m.

E. K.B. made progress in her labor, and was dilated about 3-4 cm. at 2:05 p.m. The fetal monitor showed some deep variable decelerations (to 80 bpm) with the uterine contractions and respondent ordered an amnioinfusion. By 3:47 p.m. K.B. was dilated to 6-7 cm. and still having deep variable decelerations.

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1. Neurogenic bladder means that the bladder is in a state of dysfunction due to lesions of the central or peripheral nervous system.

F. K.B. started pushing at about 9:00 p.m. She had variable decelerations to 90 bpm after almost every push/contraction.

G. Respondent did not continue to assist labor with Pitocin. He waited for about two hours, and reassessed the position of the baby.

H. Respondent manually attempted to turn the baby's head while K.B. was pushing and a nurse, pursuant to respondent's orders, applied fundal pressure. Respondent tried to turn the head three or four times. While respondent was attempting this maneuver, K.B. became completely dilated, and respondent placed her legs in high stirrups.

I. Respondent applied forceps at this point, without first activating the epidural catheter for pain relief. When the forceps were applied, the vertex was at a +1 station; respondent attempted a midforceps delivery.

J. Respondent did not take K.B. to the operating room before attempting delivery of K.B.'s baby. In addition, respondent did not have a resuscitation team (a respiratory therapist or a neonatal nursery nurse) available when he commenced the attempt to delivery the baby with forceps.

K. Respondent did not perform a caesarean section on K.B. because of her previous bladder surgeries and her neurogenic bladder.

L. Respondent applied the forceps at about 9:30 p.m. K.B. immediately complained of significant pain, and respondent stopped and called the anesthesiologist, who restarted the epidural.

M. After the epidural was restarted, respondent pulled with five or more contractions, using a side to side rocking motion. The fetal heart rate monitor showed fetal distress during the forceps procedure. The baby's head came to the perineum, respondent took off the forceps and asked K.B. to push. The head slipped back and respondent reapplied the forceps. The baby was delivered at 9:55 p.m.

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N. Respondent did not clear the baby's airway after delivery.

O. Respondent twice slipped the nuchal cord over the baby's head; the cord was loose.

P. The baby appeared extremely floppy, and respondent placed it on K.B.'s abdomen. Respondent slapped the baby repeatedly. Respondent then asked for oxygen, but only K.B.'s mask was available. The mask was too large for the baby, and the nurses called for a neonatal nursery nurse to assist in resuscitating the baby. Respondent removed the baby from K.B.'s abdomen and placed it on the warmer. Respondent continued to slap the baby while it was being intubated and bagged.

Q. C.W., R.N., charge nurse on the postpartum floor on July 24, 1999, saw respondent with K.B.'s chart on or about that date. Respondent removed a piece of paper from the chart and placed it in his pocket. Respondent wrote notes in the chart dated July 22 and July 23, 1999. Respondent appeared to be charting directly from the nurses' notes.

R. Dr. Janis Fee, M.D., reviewed respondent's progress notes for July 22, 1999, and found a half-page of notes. When Dr. Fee reviewed respondent's notes at a later time, she found that the half-page she had read the day before was missing. Instead, Dr. Fee found two pages of notes by respondent that had not been there the day before.

PATIENT T.H.

S. Patient T.H. was 27 years of age at the time in question, had been pregnant twice but had no children, and was a class B diabetic[2]. She had been on oral agents during her pregnancy and conceived while taking Clomid.

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2. As a class B diabetic, T.H. was diabetic before her pregnancy and was insulin-dependent.

T. T.H. was started on insulin by respondent at about 27 weeks after she conceived. Respondent ordered 10 units NPH and 5 units regular[3] each morning. Respondent instructed her to check blood sugar twice each day, and adjusted her insulin dosages on a weekly basis. When her fasting blood sugar levels were too high, respondent adjusted her insulin up to 45 units NPH and 40 units regular in the morning.

U. Respondent did not order nor did he note in the medical record any order for a consultation by a perinatologist.

V. Respondent started performing non-stress tests weekly starting at 34 weeks. At that time, respondent noted a planned amniocentesis for January 17, 1997, when T.H. would be in her 35th week. Respondent noted that if the patient were PG (phosphatidylglycerol) positive, he planned delivery of her baby[4].

W. On or about January 17, 1997, T.H. came to respondent's office for the amniocentesis. Respondent performed a sonogram, and learned that the fetal heart rate was 120 beats per minute or "bpm" (respondent noted that the normal fetal heart rate is 140 bpm; it is actually a range of 120-160 bpm). He also found that the placenta was large and covered almost the entire anterior uterine wall. Respondent found a clear pocket of fluid in the right lower quadrant and performed an amniocentesis.

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3. "NPH" and "regular" insulin are two different types of insulin. NPH insulin is long-acting, and "regular" insulin is short-acting. Generally, insulin-dependent diabetics need both kinds of insulin to control diabetes.

4. A positive PG value is an indication of lung maturity when PG is present in the amniotic fluid. The lungs of a diabetic baby mature more slowly than those of a non-diabetic.

X. Respondent had to puncture T.H. at least twice with the amniocentesis needle to get a sample of the fluid. The sample was tinged with blood. Respondent made no notes of how many times he inserted the amniocentesis needle into T.H.

Y. Respondent called the hospital and made plans for a "stat" caesarean section delivery. T.H. drove or walked to the hospital, and respondent arrived first. When T.H. was admitted to Labor and Delivery, no fetal heart tones were heard. The preoperative diagnosis was fetal bradycardia, or slow heart rate. The postoperative diagnosis was placental abruption, or separation of the placenta from the uterine wall. The baby's hematocrit (Hct) was 24 (it should have been around 60).

Z. Pathologic examination of the placenta did not show an abruption. The baby had seizures and died.

Medical Record No. 365409

AA. On June 6, 2002, respondent's patient, **Medical Record No. 365409**[2], was scheduled to deliver. The thirty-four year old patient had first seen respondent on or about October 8, 2001. Of significance is that her blood type was AB negative-antibody positive.

BB. At 4:45 p.m. on June 6th she was admitted with a vaginal exam which showed she was 90% effaced, 3-4 cm dilated, vertex at -1 station. At 6:45 p.m. respondent examined the patient and ruptured the membrane. Nurse Kanbar took over the patient's care and 7:00 p.m., and at 8:50 the patient was given an epidural by the anesthesiologist. During her initial assessment at 7 p.m. nurse Kanbar felt only an arm and not a head. She immediately called respondent and told him about her findings. He said that when he examined her at 6:45 p.m.

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2. Although the hospital has provided the patient's records and acknowledged that as a result of this incident it suspended respondent's hospital privileges, the hospital redacted the name of the woman involved and her identity has not yet been determined.

he, too, had felt the hand , and told her a compound presentation was not an indication for a c-section. He said the baby would move the hand, and told nurse Kanbar to continue the Pitocin and he would speak to the patient.

CC. The patient was having contractions every three to three and a half minutes. The patient experienced variable decelerations of the fetal heart rate four times and had five lates, meaning the baby's return to a baseline heart rate after a deceleration was late. After the fifth late, nurse Kanbar called respondent, this time at 11:53 p.m. She advised him of the five lates and the decelerations. Respondent told her to stop the Pitocin. She again told respondent that she did not feel comfortable feeling only the baby's arm and that respondent should come in and check the patient and the fetal monitor strip. Respondent told her not to be concerned by the arm and that he would come to the hospital.

DD. Respondent did not arrive at the hospital until twenty-eight minutes after midnight. He performed a vaginal exam and told the patient to bear down and push. Respondent had the patient push during three sets of two or three contractions.

EE. Prior to pushing, the patient had been crying saying she had waited ten years for this baby and she wanted a c-section. She asked for a c-section again after the exam. Respondent reviewed the fetal monitor strip in front of the patient and told her that the baby was fine. He told her that he invented fetal monitoring. When the patient asked why the baby's heart rate was declining, respondent said it was from the nurses giving the Pitocin. The patient continued to beg for a c-section. Respondent ultimately relented, saying he would do so only because she was not progressing not because the baby was in any danger.

FF. The baby's heart rate was fluctuating in the 50-70 range at this time. The patient kept asking respondent about the baby's hear rate. Respondent reassured her the baby was fine and left the room. When respondent left the room nurse Kanbar thought he was going to scrub. When she saw no one

scrubbing she went to find respondent who was sitting in the doctor's lounge in a chair rocking back and forth. Kanbar said the baby was not recovering and what did he want her to do, He said to give the patient some Terbutaline to stop the contractions, but he did not get up.

GG. When Kanbar returned to the room and saw that the heart rate was still down, she went back to the lounge and told respondent she would not give the medication and that he needed to come right now.

HH. Respondent went back to the room, and he performed a c-section shortly thereafter. The newborn had very low APGAR scores and was taken away by the NICU staff. When Kanbar went back to the O.R. to pull the fetal monitor strip, she found it shoved into the chart. It was the nurses job to retrieve the strip. When she did her own charting she discovered that a fifteen minute portion of the strip was missing. She asked every one involved in case except respondent if they had pulled the strip and each of them answered no.

13. Respondent's care and treatment of K.B. constituted gross negligence, incompetence and/or repeated negligent acts as more particularly set forth in this paragraph.

A. Respondent instructed the nurses to apply fundal pressure while the patient was pushing and respondent was attempting to rotate the baby's head.

B. Respondent elected to proceed with attempting to turn the baby's head followed by a forceps delivery, instead of continuing to administer Pitocin and waiting a reasonable time (about two hours) for the head to turn and come down on its own.

C. Respondent placed the stirrups for K.B. in the wrong position.

D. Respondent should have activated (or caused to be activated) the epidural catheter before he placed the forceps.

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E. Respondent attempted a forceps delivery without taking K.B. to the operating room.

F. Respondent did not have a resuscitation team in the room before the delivery.

G. Respondent used an extreme side-to-side rocking motion while pulling the infant with the forceps.

H. Respondent pulled more than five times with K.B.'s contractions.

I. Respondent removed the forceps from the baby before its head came out, and failed to realize that K.B. would not give birth spontaneously at that point.

J. Respondent applied the forceps and tried to effect the delivery when the vertex was at +1, but documented that the vertex was at +2 in the chart.

K. Respondent charted the fact that the nuchal cord was tight, when in fact it was loose.

L. Respondent failed to clear the baby's airway prior to the delivery of the shoulders.

M. After delivery, respondent failed to immediately take the baby to the warmer and begin resuscitation. Instead, respondent excessively slapped the baby and placed it on its mother's abdomen.

N. Respondent did not perform a caesarean section on K.B. because she had a history of neurogenic bladder and had two bladder surgeries in her youth. This history is not a contraindication for caesarean section.

O. Respondent altered the medical record of his care and treatment of K.B.

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14. Respondent's care and treatment of T.H. constituted gross negligence, incompetence and/or repeated negligent acts as more particularly set forth in this paragraph.

A. Respondent should have taken T.H. off oral agents and instituted insulin therapy before putting T.H. on Clomid.

B. Once T.H. was pregnant, respondent should have ordered her to test blood sugar 4-7 times a day instead of only twice, and should have instructed her to consult with him almost daily to adjust insulin dose instead of once a week. T.H. should have received additional insulin doses each day.

C. Respondent failed to appropriately monitor and control T.H.'s diabetes.

D. Respondent failed to institute fetal surveillance with non-stress tests on a biweekly basis starting at between 30 and 32 weeks of pregnancy.

E. Respondent failed to chart any notes of a consultation with a diabetes expert that respondent claims to have had.

F. Respondent performed the amniocentesis without clinical indication.

G. Respondent failed to recognize that a fetal heart rate of 120 bpm is not bradycardia.

H. If respondent thought that there was bradycardia or other fetal distress, he should have sent T.H. to the Labor and Delivery Unit at the hospital for monitoring, which he failed to do.

I. Respondent improperly performed the amniocentesis in that he failed to perform the procedure either in the Labor and Delivery Unit or immediately adjacent to that Unit.

J. Respondent failed to get a perinatologist consultation for T.H. during her pregnancy.

K. Respondent failed to recognize that T.H.'s large anterior placenta increased the risk of performing an amniocentesis if that procedure were

necessary. Respondent also increased the danger to patient T.H. and her baby by making multiple punctures with the amniocentesis needle.

15. Respondent's care and treatment of Medical Record No. 365409 constituted gross negligence, incompetence, and/or repeated negligent acts as more particularly set forth in this paragraph.

A. Respondent induced the patient in the absence of a vertex presentation.

B. Respondent ruptured the membrane with the vertex in the pelvis.

C. Respondent had the patient push at 6 cm when she was already having decelerations.

D. Respondent failed to perform a crash c-section.

E. Respondent tampered with the medical record by ripping out fifteen minutes of the fetal monitor strip.

SECOND CAUSE FOR DISCIPLINE

(Making False Statements)

16. Respondent is subject to disciplinary action under Code section 2261in that he made false statements regarding his care and treatment of K.B.,T.H., and Medical Record No. 365409. The circumstances are as follows:

A. Paragraph 11 of this Accusation is incorporated by reference and is hereby realleged as if set forth in full.

PATIENT K.B.

B. Respondent charted that he tried to effect delivery when the vertex was at +2, when in fact it was at +1.

C. Respondent charted that the nuchal cord was tight, when in fact it was loose.

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D. Respondent's chart notes for July 22, 1999 and July 23, 1999, were placed in the chart at a later time, and that fact was not recorded in the chart by respondent.

E. Respondent's chart notes for July 22, 1999 and July 23, 1999, were made from the nurses notes rather than respondent's own recollection, and that fact was not recorded in the chart by respondent.

PATIENT T.H.

F. Respondent falsely noted in the record that he was performing the amniocentesis for bradycardia, when in fact the amniocentesis was planned in advance.

G. Respondent falsely stated that there was a fetal abruption, when in fact both clinically and pathologically there was no evidence of abruption.

MEDICAL RECORD NO. 365409

H. Respondent falsely documented the patient's desires regarding having an AFP.

THIRD CAUSE FOR DISCIPLINE

(Alteration of Medical Records)

17. Respondent is subject to disciplinary action under section 2262 in that he altered the medical records of his care and treatment of K.B. , and Medical Record No. 365409. The circumstances are as follows:

A. Paragraph 11 of this Accusation is incorporated by reference and is hereby realleged as if set forth in full.

PATIENT K.B.

B. On or about July 23, 1999, respondent removed his original chart notes regarding his care and treatment of K.B. on July 22, 1999, which consisted of approximately one-half page.

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C. Respondent replaced his original one-half page of notes with two pages of notes he wrote directly from the nurses notes.

MEDICAL RECORD NO. 365409

D. Respondent removed fifteen minutes from the fetal monitor strip from the patient's records.

FOURTH CAUSE FOR DISCIPLINE

(Failure to maintain adequate records)

18. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to maintain complete, adequate and accurate records of his care and treatment of K.B., T.H. and Medical Record No. 365409. The circumstances are as follows:

A. Paragraph 11 of this Accusation is incorporated by reference and is hereby realleged as if set forth in full.

PATIENT K.B.

B. Respondent charted that he tried to effect delivery when the vertex was at +2, when in fact it was at +1.

C. Respondent charted that the nuchal cord was tight, when in fact it was loose.

D. Respondent's chart notes for July 22, 1999 and July 23, 1999, were placed in the chart at a later time, and that fact was not recorded in the chart by respondent.

E. Respondent's chart notes for July 22, 1999 and July 23, 1999, were made from the nurses notes rather than respondent's own recollection, and that fact was not recorded in the chart by respondent.

F. On or about July 23, 1999, respondent removed his original chart notes regarding his care and treatment of K.B. on July 22, 1999, which consisted of approximately one-half page.

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G. Respondent replaced his original one-half page of notes with two pages of notes he wrote directly from the nurses notes.

PATIENT T.H.

H. Respondent falsely noted in the record that he was performing the amniocentesis for bradycardia, when in fact the amniocentesis was planned in advance.

I. Respondent falsely stated that there was a fetal abruption, when in fact both clinically and pathologically there was no evidence of abruption.

MEDICAL RECORD NO. 365409

J. Respondent removed fifteen minutes from the fetal monitor strip from the patient's records.

K. Respondent falsely documented the patient's desires regarding having an AFP.

FIFTH CAUSE FOR DISCIPLINE

(Acts of Dishonesty or Corruption)

19. Respondent is subject to disciplinary action under section 2234(f) of the Code in that he committed acts involving dishonesty or corruption substantially related to the duties of a physician and surgeon in his care and treatment of K.B. , T.H. and Medical Record 365409. The circumstances are as follows:

A. Paragraph 11 of this Accusation is incorporated by reference and is hereby realleged as if set forth in full.

PATIENT K.B.

B. Respondent charted that he tried to effect delivery when the vertex was at +2, when in fact it was at +1.

C. Respondent charted that the nuchal cord was tight, when in fact it was loose.

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D. Respondent's chart notes for July 22, 1999 and July 23, 1999, were placed in the chart at a later time, and that fact was not recorded in the chart by respondent.

E. Respondent's chart notes for July 22, 1999 and July 23, 1999, were made from the nurses notes rather than respondent's own recollection, and that fact was not recorded in the chart by respondent.

F. On or about July 23, 1999, respondent removed his original chart notes regarding his care and treatment of K.B. on July 22, 1999, which consisted of approximately one-half page.

G. Respondent replaced his original one-half page of notes with two pages of notes he wrote directly from the nurses notes.

PATIENT T.H.

H. Respondent falsely noted in the record that he was performing the amniocentesis for bradycardia, when in fact the amniocentesis was planned in advance.

I. Respondent falsely stated that there was a fetal abruption, when in fact both clinically and pathologically there was no evidence of abruption.

MEDICAL RECORD NO. 365409

J. Respondent removed fifteen minutes from the fetal monitor strip from the patient's records.

K. Respondent falsely documented the patient's desires regarding having an AFP.

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SIXTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

20. Respondent is subject to disciplinary action under section 2234 of the Code in that he committed general unprofessional conduct[3] in his care and treatment of K.B., T.H., and Medical Record No. 365409. The circumstances are as follows:

A. Paragraph 11 of this Accusation is incorporated by reference and is hereby realleged as if set forth in full.

B. Paragraphs 12, 13, and 14 of this Accusation are incorporated by reference and are hereby realleged as if set forth in full.

THE GYNECOLOGICAL PATIENTS

SEVENTH CAUSE FOR DISCIPLINE

(Gross negligence, repeated negligent acts, incompetence)

21. Respondent is subject to disciplinary action under section 2234 of the Code in that he was grossly negligent, incompetent, and/or committed repeated negligent acts in his care and treatment of patients S.G., D.M-G., L.M., J.S.M., M.P., B.P., D.S., J.L.M., A.Y., B.R., J.W., M.A., B.J.G., and V.G. The circumstances are as follows:

PATIENT S.G.

A. Respondent first saw S.G. on November 27, 1996, at which time an office sonogram was done and was found to show "? adenomyosis vs. fibroids." Respondent told the patient she had adenomyosis and that she would "burst and bleed to death" if she did not have the surgery respondent recommended right away. Prior to the surgery S.G. went to the Red Cross and donated her own blood in case she needed it for surgery.

B. On November 13, 1997, respondent saw the patient for right side pain and was given options of Lupron or "BSO".

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3. General unprofessional conduct is defined as that conduct which breaches the rules or ethical code of a profession, or conduct which is unbecoming a member in good standing of a profession. Shea v. Board of Medical Examiners (1978) 81 Cal.App.3d 564, 578.

C. On November 25, 1998, an office sonogram showed a complex right ovarian cyst.

D. On December 18, 1998, the 33-year-old patient was admitted for evaluation of pelvic pain, recurrent endometriosis and ovarian cyst. She underwent enterolysis, bilateral salpingo-oophorectomy, fulguration of endometriosis and cystoscopy. At no time following the surgery was the patient offered blood despite the fact she was significantly anemic post-operatively.

E. During the time S.G. was undergoing post-operative hormone replacement, respondent refused to take calls from her.

PATIENT D. M-G.

F. On June 19, 1997, respondent saw D.M-G., a fifty-two year old woman whose last period was in 1991. The patient complained of vaginal bleeding for two weeks, pain in her lower abdomen for one month, and sever pelvic pain for three weeks. Respondent also documented the patient had urinary incontinence and deep dysparuenia as complaints.

G. On October 18, 1997, D.M-G. underwent a laparoscopic assisted vaginal hysterectomy, bilateral salpingo-oophorectomy, umbilical hernia repair, enterocele repair, rectocele repair, lysis of adhesions, and Burch procedure.

H. During a post-operative visit on November 5, 1997, the patient complained of numerous things including back pain, for which respondent planned to order as MRI at 6-8 weeks to evaluate for disc disease.

I. On November 11, 1997, respondent saw the patient for low back pain and dysuria, which was attributable to disc disease. A cath. urine specimen tested positive for blood and negative for leucocytes.

J. On November 20, 1997, D.M-G. had numerous complaints including pain in the lower right back. A urine test again showed blood, and this time trace leucocytes. Respondent diagnosed her as having a urinary tract infection.

K. On January 8, 1998, respondent treated the patient with Cipro for a positive urine sample. Again there was blood in the urine, as there was on February 5, 1998.

L. On February 5, 1998, the patient presented with complaints of lower abdominal pain, dysuria and burning inside her vagina. Respondent concluded she had poor perineal tone and referred the patient for perineal exercises.

M. On March 16, 1998, D.M-G. complains of bladder pressure. Respondent concludes she had cystitis and monilia vaginitis. A urine culture was negative but it did have 250 ery\uL and +1 leucocytes. The urine was negative for leucocytes on April 7, 1998, but did show 250ery\uL.

N. On April 14, 1998, the patient underwent urethral dilation, and blood was again noted in the urine.

O. On May 6, 1998, the patient had complaints of pressure and the feeling of something falling out. A urology consult was advised and the plan was for lysis of adhesions and vaginal vault suspension.

P. On May 28, 1998, Dr. B. found D.M-G. had a complete right distal ureter obstruction extending for 1-2 cm located 2-3 cm from the bladder and a stone on the left side of the bladder. He performed a cystoscopy, right retrograde pyelogram, antegrade nephrostograms, transuretral resection of bladder tumor and bladder stone removal. The initial report was early low-grade papillary transitional cell cancer but this was later changed to benign.

Q. On August 8, 1998, Dr. B. removed the patient's right kidney.

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PATIENT L. M.

R. On September 25, 1997, respondent saw L.M. who complained of painful sexual intercourse and painful menstrual periods. A sonogram revealed a multi-cystic left ovary with septations and a small mass on the posterior aspect of the uterus. A laparoscopy was planned.

S. The laparoscopy was performed on October 3, 1997. The operative findings included endometriosis, a small fundal myoma, right ovarian endometriosis and a left ureteral implant.

T. On December 15, 1998, an office sonogram was performed. Respondent's records describe a left ovarian cyst "dermoid?-fibroid and adenomyosis". There are six unlabeled images.

U. On April 7, 1999, respondent's office performed another sonogram to evaluate abdominal pain. There are four unlabeled images from this procedure.

V. On May 14, 1999, the patient underwent another laparoscopic procedure for right side pelvic pain and an abnormal pap smear. Cystic left and right ovaries were found, along with adhesions.

W. On January 6, 2000, the patient presented with complaints of pelvic pain. An office sonogram was performed with the finding being "adenomyosis . . . complex/mass extending R ovary to behind the ut?". There are six unlabeled images.

X. On May 1, 2000, L.M. underwent a laparoscopic removal of the gall bladder and lysis of the right lower quadrant adhesions by Dr. S.

PATIENT J. S. M.

Y. On August 29, 1996, respondent saw 51-year-old patient J.S.M. who complained of a lump on the right side of her vaginal labia. During this visit a right pelvic mass 6x6cm and a left pelvic mass 4x4 cm were discovered. A colposcopic biopsy was done. The patient's records failed to

document an examination of the vaginal labia relating to the patient's chief complaint, although the plan documented indicated "she will prob. have LAVH [laparoscopic hysterectomy]-BSO, ?Burch?" which are surgical procedures.

Z. On a follow-up visit an office ultrasound was performed. The records contain two unlabeled printouts. There is also documented "?fibroids, left ovary tender mass 5x5 cm right is abnormal? fibroid 6x6 cm, although there are no printouts documenting these findings."

PATIENT M.P.

AA. On August 7, 1995, 43 year-old M.P. saw respondent for a chief complaint of irregular bleeding, which had been going on for weeks. The patient said she was feeling crampy. An office sonogram was performed and the record contains four unlabeled images. Respondent diagnosed adenomyosis. The plan was for the patient to undergo an endometrial biopsy and endocervical curettage, along with a laparoscopic hysterectomy (LAVH) and bilateral salpingo-oophorectomy.

BB. On August 10, 1995, respondent treated the patient with 150 mg of Depoprovera. Plan was for a LAVH.

CC. On September 25, 1995, respondent noted the patient had mild stress urinary incontinence, spotting and bleeding which did not stop with the Depoprovera treatment. An office sonogram was performed and the report from the test stated "adenomyosis and a 2 mm endometrial stripe." The impressions was adenomyosis, failed medical management, and the plan was for a LAVH-BSO, with a possible Burch procedure.

DD. On October 6, 1995, the patient underwent a LAVH-BSO with lysis of dense pelvic adhesions and a laparoscopic Burch. Although an appendectomy was missing from a listing of the procedures performed, the operative report described an appendectomy having been performed as well.

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EE. On June 27, 1996, the patient's chief complaint was "leaking urine." On July 8, 1996, the patient complained of pain in both hips and was referred to a physical therapist. On July 31, 1996, it was noted that the patient was wearing a pad with exercise, although respondent wrote "wears no pads and no urine leakage." On August 6, 1996, M.P.'s chief complaint was again urine leakage.

FF. On September 18, 1996, the patient complained of "milky discharge, no odor. Itch on and off." Respondent noted "no urine loss" and "bladder well supported."

GG. On October 14, 1996, the patient is taking 1.25 mg of Premarin per day. She complained of a heavy feeling in her pelvis, "like something is falling out."

HH. On May 21, 1999, M.P. sees Dr. S. complaining of pelvic pain.

II. On July 13, 1999, the patient underwent laparoscopy, lysis of adhesions and anterior colporraphy. Among the findings made by Dr. S. was the viewing of a staple line "across the distal one-third of the appendix". Small bowel adhesions were noted to the anterior abdominal wall.

PATIENT B.P.

JJ. In May 1994 patient B.P. saw respondent who documented in the patient's history that she had complaints of severe dysmenorrhea and P.M.S. The plan was for a diagnostic laparoscopy. In January 1996 respondent again recommended the patient have a laparoscopy. In May 1998 respondent treated the patient with oral contraceptives and again felt she probably needed a laparoscopy.

KK. Respondent performed the laparoscopy on B.P on June 5, 1998.

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LL. On February 3, 1999, at the age of 27 the patient returned complaining of lower abdominal pain and deep dysparuenia. Respondent diagnosed the patient as having pelvic endometriosis.

MM. Respondent next saw the patient on March 1, 1999, at which time she complained of dysmenorrhea. The patient was to consider Lupron, but she was treated with Motrin, Vicodin, Depoprovera and Toradol. Eight days later the plan was for surgery.

NN. On March 12, 1999, B. P. underwent a laparoscopy, tubal dye study, laser of endometriosis, lysis of adhesions, and presacral neurectomy

OO. In November 1999 the patient was diagnosed as having a urinary tract infection.

PP. On December 7, 1999, the patient was assessed as having a urinary tract infection with hematuria. On January 4, 2000, the patient complained of bladder pain and that the medications she was taking were making her nauseous. On March 21, 2000, the patient presented for a re-check and a possible urinary tract infection.

PATIENT D.S.

QQ. Respondent saw D.S. on August 28, 1995, for lower abdominal pain. An office sonogram was performed which reported findings of "adenomyosis, fibroids. A drawing of a 4x5 cm area on the right side of the uterus labeled fibroid appears in the record although it is not documented in the printout images. A LAVH-BSO was performed on September 8, 1995. The pathology report showed a 1.8 cm endometrial polyp and multiple myomas. D.S. was given Depoprovera post-operatively.

RR. On March 10, 1997, D.S. presented back to respondent with a chief complaint of possible bladder infection. A diagram in the chart shows a "2+" tenderness in the left upper quadrant and left mid-abdomen.

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SS. On October 27, 1997, D.S. saw respondent for a surgical consult. Respondent noted the patient had pain post LAVH and liposuction, and that she has adhesive bowel disease. The plan was for a diagnostic laparoscopy.

TT. Respondent performed a history and physical on D.S. on October 31, 1997. The chief complaint was noted as chronic pelvic pain. No bowel prep was performed pre-operatively. That same date a diagnostic laparoscopy and lysis of dense pelvic adhesions was performed.

UU. Post operatively D.S. had difficulty. She had pain, abdominal distention, and, on the third day post-operatively, her bowel sounds were absent on three occasions, and she awakened with nausea and great pain. On the fourth post-operative day tests revealed there was free intraperitoneal air in the patient. Respondent planned a CT scan for the following day, November 5, 1997.

VV. On November 5, 1997, D.S. was operated on and a single perforation of the small bowel was found. Post-operatively the patient required intubation and was transferred to Intensive Care for treatment of sepsis. On November 14, 1997, D.S. was taken back to the operating room for an exploratory laparotomy and drainage of multiple abscesses.

PATIENT J. L. M.

WW. On April 12, 1999, respondent saw patient J.L.M., who was complaining of excessive bleeding during her menstrual cycles, pain, and pain during intercourse. An office sonogram was done which found possible endometrial polyp and adenomyosis. No CBC was ordered that day.

XX. Five days after her initial office visit, on April 17, 1999, respondent performed a LAVH-BSO and appendectomy on J.L.M. During the surgery, respondent placed staples over the pedicle to control bleeding which was seen in the area of the left infundibulopelvic ligament. Thereafter, post-operatively, the patient complained of pain and left sided pain.

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YY. Between April 19 and October 4, 1999, respondent prescribed 368 Vicodin tablets for J.L.M. In September respondent also prescribed her Phentermine.

ZZ. On December 7, 1999, Dr. S. performs a laparoscopy on J.L.M. to evaluate her complaint of pelvic pain since the LAVH. Along the left pelvic brim, Dr. S. found a "fairly large staple affixing the sigmoid to the pelvic side wall."

PATIENT A.Y.

AAA. Respondent first saw patient A.Y. on November 21, 1996, when she was 22 years old. The patient was complaining of painful menstrual period. Respondent advised the patient to have a diagnostic laparoscopy and prescribed Demulen in addition to the Motrin the patient was already taking.

BBB. During this visit with the patient, respondent attempted to scare the patient into having surgery immediately, scheduling her for the following week. He advised the patient she would be unable to have children with her endometriosis, and suggested she have a child out of wedlock since pregnancy helps endometriosis.

CCC. A.Y. sought a second opinion from a Dr. A.D.V. on December 2, 1996. Dr. D.V.'s plan was for a diagnostic laparoscopy or oral contraceptives.

DDD. On October 19, 1998, A.Y. saw a Dr. B. telling him she had been crampy since age 16. Although Dr. B. discussed a possible diagnostic laparoscopy, it was not felt to be needed at that time. Dr. B. saw her again on October 14, 1999, and described the patient as a well woman.

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PATIENT B.R.

EEE. Patient B.R. saw respondent on January 7, 1998, for a six week post partum visit and a Pap smear. The pap was unsatisfactory with inflammation and poor fixation. A repeat Pap on April 4, 1998, was reported as class II.

FFF. On May 6, 1998, respondent performed a colposcopic directed biopsy as well as an ECC. The biopsies suggested HPV and a condition bordering on mild dysplasia. The ECC was negative. Respondent performed cryosurgery on the cervix on May 26, 1998.

GGG. B.R. had a Pap smear on August 28, 1998, which was found to be class II and she was treated with Cleocin cream. A follow-up Pap smear on November 4, 1998, was noted to be a class II with benign cellular changes. Respondent noted in the records that the patient needed a "colpo."

HHH. Respondent's colposcopy note of November 17, 1998, makes no mention of whether the lesions were seen on examination. The tissue examined showed atypical squamous metaplasia and mild dysplasia.

III. On November 23, 1998, respondent recorded the plan for B.R. as being either "cone/LAVH [hysterectomy]".

JJJ. At the time respondent recommended B.R. undergo a hysterectomy, he told her the condition would turn into cancer and that it may be too late if she did not have the surgery. Respondent further recommended that he remove the patient's appendix and ovaries.

KKK. On January 7, 1999, B.R. sought a second opinion from Dr. Janis Fee, M.D. While seeing Dr. Fee the Pap smear results were as follows: (1) January 7, 1999, negative; (2) March 9, 1999, atypical metaplasia, ASCUS; (3) August 5, 1999, reactive cellular changes associated with inflammation; (4) May 5, 2000, negative.

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PATIENT J.W.

LLL. Thirty-one year old **J.W.**, she first saw respondent in October/November 2001 because she had stopped having periods, and would experience abdominal cramps during intercourse with her husband. On exam respondent told J.W. she had a tumor on her uterus and cystic fibrosis on both her ovaries. She was told she needed a hysterectomy. He advised her to have immediate surgery, because to wait could be life threatening. At no time did respondent discuss alternatives to surgery.

MMM. On November 30, 2001, respondent performed a laparoscopic hysterectomy on J.W. at Western Medical Center. [4] After the surgery J.W. experienced severe pain for which respondent gave her Cortisone injections. Hereafter, J.W. developed red pimple like blotches over her body which respondent diagnosed as chicken pox despite the fact J.W. had already the chicken pox. J.W. went to a dermatologist who told her she had an allergic reaction to the steroids she had received.

PATIENT M.A.

NNN. Forty-six year old M.A. first saw respondent in November 2000, for a well woman check, and informed respondent that she occasionally had painful periods. On this first visit respondent told M.A. she needed a hysterectomy because of endometriosis. M.A.'s husband told respondent there were too many risks and they decided not to have the surgery. On that first visit, respondent gave the patient samples of the hormone Femehrt, and told her to take them.

OOO. During the next year M.A. would take the hormone, and receive more from respondent's office when she ran out.

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4. Petitioner is advised and believes that respondent has had his privileges suspended from Western Medical Center. The Medical Board has yet to be formally advised of this at the time of this Petition's preparation.

PPP. The next examination by respondent was done on or about November 28, 2001. She told respondent she had severe headaches. Respondent performed a sonogram and informed M.A. and her husband that she had three tumors, one the size of a golf ball and two smaller ones. Respondent advised M.A. to have an immediate hysterectomy because the tumors could be cancerous. She was told to call her husband and have him come into the office.

QQQ. The next day, November 29, 2001, she returned with her husband who asked respondent if the hysterectomy was absolutely necessary. Respondent told them about a patient he had just performed the surgery on who he was not sure was going to survive because she had waited so long and her cancer had spread. On December 7, 2001, respondent performed a laparoscopic hysterectomy on M.A. at Western Medical Center.

RRR. When she returned for her post-operative visit on December 13, 2001, respondent told M.A. the pathology showed the tumors were pre-cancerous. M.A. complained to respondent of pain on her right side. Respondent said this was normal.

SSS. On December 26, 2001, M.A. started bleeding heavily. She went to see respondent who said it was normal bleeding from the stitches. On January 5, 2002, M.A. was in such pain she could not get up. She was crying and needed help in walking. She saw respondent who injected something into her belly button. When she returned to respondent on January 10, 2002, he told her she needed surgery the next day to clean up scar tissue.

TTT. On January 11, 2002, M.A. underwent a second laparoscopic procedure at Western Medical. On January 17, 2002, M.A. saw respondent for a follow-up appointment. Although she had some pain, Rutland told her everything was fine. When she returned again in February 2002, M.A.

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told respondent she was now experiencing a loss of urine when she coughed or laughed. Respondent examined M.A. and gave her antibiotics for an infection. Two weeks later he checked her again and changed her antibiotics.

PATIENT B.J.G.

UUU. Forty year old B.J.G. first saw respondent in March 2001, for a well woman exam. She told respondent she had painful periods and that every three months she would vomit during her period. Respondent discussed her having a hysterectomy during this first visit. He also performed a Q-tip test and told B.J.G. her bladder needed to be lifted, although the patient did not think her urine leakage was a problem. When B.J. G. asked respondent if taking birth control medication would help he said that if she was done having children she should have the hysterectomy.

VVV. B.J.G. Told respondent she had a history of abnormal pap smears, but there was never any pathology showing a problem. When she was twenty-right years old B.J.G. was told she had a mild case of endometriosis not requiring any further treatment.

WWW. B.J.G. had another appointment with respondent in March 2001, at which time she brought her husband. At this meeting respondent told the patient she had an abnormal pap smear, one level higher than any of the other abnormal pap smears she had in the past. He told her it was a sign of pre-cancerous cells that had the likelihood of becoming cancerous. Respondent also told the patient she had HPV and that he felt something on her uterus during his exam. He told her she had severe endometriosis. Respondent told the patient that while he was operating he would remove her appendix and lift her bladder at no extra charge. When B.J.G. told respondent she wanted some time to think about the surgery, respondent replied , "what's there to think about. All the time you wait, cancer could spread." Respondent's front nurse then was brought into the

room and explained to B.J.G. that respondent had saved her life by performing that same surgery. She said her sex life had improved dramatically.

XXX. A few days after seeing respondent, B.J.G. went to Western Medical Center in terrible pain. She was told a cyst most likely burst and they gave her medication. Given what respondent had told her B.J.G. then consented to the surgery. Respondent performed the hysterectomy, appendectomy, and bladder surgery on or about march 30/31, 2001. When she saw respondent post surgically for the first time, he told she was "infested" with endometriosis, and on a scale of one to ten she had been a ten plus. Respondent told B.J.G.'s husband they found no cancer and were lucky to have caught the problem when they did.

YYY. After the surgery B.J.G. had fever, vomiting and was placed on antibiotics for six weeks. B.J.G. told respondent she had been crying and feeling depressed, unable to get out of bed. In return, respondent gave the patient a lunch bag full of Zoloft samples and told her to try them. When B.J.G. continued to feel bad after the surgery she went to another physician for an opinion.

ZZZ. Dr. T. examined the records from Western Medical and told her the hospital pathology report showed little endometriosis and no evidence of HPV.

PATIENT V.G.

AAAA. Patient V.G. had treated with respondent since 1987, having first met him in law school during the early 1980'2. In 1993 respondent had performed a complete hysterectomy on her in 1993. Over the course of the years she had complained to respondent about urine leakage when she coughed or sneezed. Respondent had told her she needed a bladder lift, and, on or about June 16, 2000, respondent performed a bladder suspension surgery on her at Western Medical Center. The operative report from the procedure described "dense adhesions of the small bowel to the anterior wall . . ." The patient's

appendix was removed although the path report on the appendix indicated it was normal.

BBBB. On the first post operative day the patient's hbg fell from 11.7 to 8.7. On the second post operative day the patient had an ileus[5]. On the third post operative day her hbg was 7.4 and the patient was complaining of chest pain and shortness of breath. She was also complaining of abdominal pain. On the fourth post operative day her pulse was 115-120 and her hbg was 7.1. She was felt to be anemic and was given three units of blood. On the fifth post operative day she had still not had a bowel movement, and her abdomen was distended and tender. She was assessed as having peritonitis and ileus. An abdominal x-ray was taken and showed "persistent pnuemoperitonium". That afternoon a surgery consult was requested.

CCCC. On the sixth post-operative day, June 22, 2000, V.G. complained of severe pain in her back. Her oxygen saturation was 78% and her respirations were shallow and labored. She was taken to the operating room that day where a 2mm laceration of the small bowel was found.

DDDD. On he fourth post operative day after the second surgery V.G. developed a fever and an elevated white count. Three days later, on June 29, 2000, a CT scan reveals a 7cm abscess anterior to the rectum and a 3cm right upper quadrant abscess. A colpotomy drainage was performed on June 30, 2000, and V.G. was finally discharged home on July 4, 2000, eighteen days after her admission.

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5. An ileus is an obstruction of the bowel

EEEE. In 1998 during the time V.G. was scheduled for her yearly examination, she and respondent engaged in sexual intercourse in respondent's office following his examining her vaginally. Although this was the only act of intercourse to have occurred during the time respondent treated V.G., he always hugged and kissed her during office visits, and talked to her about his problems.

22. Respondent's care and treatment of S.G. constituted gross negligence, incompetence and/or repeated negligent acts as more particularly set forth in this paragraph.

A. The sonograms taken on November 27, 1996, did not demonstrate myomas or adenomyosis.

B. Respondent attempted to scare the patient into having surgery by telling her she would "burst and bleed to death" if she did not have the surgery.

C. Respondent falsely recorded that the patient refused her own blood following the surgery.

D. Respondent failed to offer the patient blood following surgery despite the fact she had donated her own blood pre-operatively.

23. Respondent's care and treatment of D.M-G. constituted gross negligence, incompetence and/or repeated negligent acts as more particularly set forth in this paragraph.

A. Respondent failed to advise the patient on conservative treatment options for her condition.

B. Respondent failed to perform an adequate urologic workup, and failed to adequately document the extent of the patient's pelvic relaxation.

C. Respondent failed to check for ureteral patency at the completion of the case.

D. Respondent failed to perform the cystocele repair as planned.

E. Respondent failed to recognize the signs and symptoms of urologic injury post-operatively.

24. Respondent's care and treatment of L.M. constituted gross negligence, incompetence and/or repeated negligent acts as more particularly set forth in this paragraph.

A. Respondent improperly diagnosed adenomyosis from the sonogram images.

B. Respondent attempted to scare L.M. into having surgery by telling her the problem with her cervix could turn into cancer in 5 weeks.

C. In January 2000, respondent told L.M. she needed immediate surgery to remove a right ovarian tumor. Although a cancer specialist Dr. M. did not see any tumor and offered to due an ultrasound within the week, respondent scared L.M. into having the surgery immediately.

D. Respondent falsified L.M.'s patient questionnaire by circling items she left blank. She did not have complaints of painful intercourse or urinary incontinence.

E. Respondent told L.M. he was an oncologist which is not true.

25. Respondent's care and treatment of J.S.M. constituted gross negligence, incompetence and/or repeated negligent acts as more particularly set forth in this paragraph.

A. Respondent failed to address the patient's complaint of a lump on her right vaginal labia.

B. Respondent failed to adequately document the patient's history of incontinence.

C. Respondent focused on the patient's adnexal masses despite the fact there is no sonographic documentation of such masses.

D. Respondent recommended the patient undergo major surgery based on limited and inaccurate information.

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26. Respondent's care and treatment of M.P. constituted gross negligence, incompetence and/or repeated negligent acts as more particularly set forth in this paragraph.

A. The September 25, 1995, sonogram did not support a diagnosis of adenomyosis.

B. Respondent failed to recommend a dilation and curettage before recommending major surgery.

C. Respondent recommended two doses of Depoprovera despite the fact one dose lasts for three months.

D. Respondent performed a Burch procedure without urodynamic testing and in the face of minimal, if any, symptoms.

E. Respondent failed to perform a complete appendectomy.

27. Respondent's care and treatment of B.P. constituted gross negligence, incompetence and/or repeated negligent acts as more particularly set forth in this paragraph.

A. Respondent advised the patient to have surgery a mere five days after being treated with medications meant for long term treatment.

B. The patient's symptoms and findings did not support respondent's performing of a presacral neurectomy.

C. Respondent inadequately treated the patient's post-operative urinary tract infections, and failed to refer her to a urologist.

28. Respondent's care and treatment of D.S. constituted gross negligence, incompetence and/or repeated negligent acts as more particularly set forth in this paragraph.

A. Respondent was not able to diagnose adenomyosis on the sonogram of this patient.

B. Respondent diagnosed a large myoma from a sonogram on which none appears.

C. Respondent failed to order a bowel prep pre-operatively.

D. Respondent failed to obtain an intra operative general surgery consultation at the time of the laparoscopy.

E. Respondent failed to diagnose and treat the patient's bowel perforation in a timely fashion.

29. Respondent's care and treatment of J.LM. constituted gross negligence, incompetence and/or repeated negligent acts as more particularly set forth in this paragraph.

A. Respondent failed to perform a pre-operative endometrial sampling.

B. Respondent failed to advise the patient about having a hysteroscopy and dilation and curettage prior to her having surgery.

C. Respondent failed to recognize and evaluate the cause of the patient's post-operative pain, and failed to recognize the injury to the genito-femoral nerve in a timely fashion.

D. Respondent inappropriately diagnosed adenomyosis on the basis of the patient's sonogram.

E. Respondent excessively prescribed the patient Vicodin between April 19 and October 4, 1999.

30. Respondent's care and treatment of A.Y. constituted gross negligence, incompetence and/or repeated negligent acts as more particularly set forth in this paragraph.

A. Respondent attempted to scare the patient into having surgery by telling her she would be unable to have children because of her endometriosis and advising her to have children out of wedlock.

31. Respondent's care and treatment of B.R. constituted gross negligence, incompetence and/or repeated negligent acts as more particularly set forth in this paragraph.

A. Respondent recommended a hysterectomy for B.R., when, in fact, mild dysplasia spontaneously remits a many cases and she needed, at most, a cone biopsy.

B. Respondent tried to coerce the patient into agreeing to the hysterectomy surgery by scaring her.

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C. Respondent's approach to the evaluation of abnormal Pap smears reflects a lack of knowledge regarding current management for abnormal results.

32. Respondent's care and treatment of J.W. constituted gross negligence, incompetence and/or repeated negligent acts as more particularly set forth in this paragraph.

A. Respondent performed major surgery on J.W. in the absence of a supportable diagnosis.

B. Respondent's history and work-up of the patient's chronic pelvic pain and dysparuenia were inadequate.

C. Respondent diagnosed the patient as having chicken pox despite the fact she had them earlier in life.

D. Respondent scared the patient into having the major surgery by lying about the true nature of her condition.

33. Respondent's care and treatment of M.A. constituted gross negligence, incompetence and/or repeated negligent acts as more particularly set forth in this paragraph.

A. Respondent took M.A. to surgery nine days after discovering an ovarian cyst, and in the absence of any evidence of suspicions for cancer.

B. Respondent performed a hysterectomy for dysmenorrhea of unknown duration and cause.

C. Respondent performed a hysterectomy for heavy menses in the absence of careful evaluation as to its degree and duration.

D. Respondent scared the patient into having the major surgery by lying about the true nature of her condition.

34. Respondent's care and treatment of B.J.G. constituted gross negligence, incompetence and/or repeated negligent acts as more particularly set forth in this paragraph.

A. Respondent took the patient to surgery seven days after first seeing respondent in the absence of any evidence of any adenomyosis.

B. Respondent failed to treat the patient's complaints with a diagnostic laparoscopy.

C. Respondent lied to the patient about the extent of he endometriosis, as the path report showed a minimal to mild case, not an infestation as described by post operatively by respondent.

D. Respondent scared the patient into having the major surgery by lying about the true nature of her condition.

E. Respondent's work-up of the patient's urinary complaint was inadequate.

35. Respondent's care and treatment of V.G. constituted gross negligence, incompetence and/or repeated negligent acts as more particularly set forth in this paragraph.

A. Respondent failed to take V.G. back into surgery given her constellation of post operative signs and symptoms involving an acute abdomen.

B. Respondent engaged in sexual relations with a patient.

C. Respondent's work-up of the patient's urine loss was inadequate.

D. Respondent failed to get an intra-operative surgical consult despite the presence of small dense adhesions of the small bowel.

EIGHTH CAUSE FOR DISCIPLINE

(Dishonest Acts)

36. Respondent is subject to disciplinary action under section 2234(e) of the Code in that he committed dishonest acts substantially related to the qualifications, functions, or duties of a physician in his care and treatment of patient S.G., D.M-G., L.M., A.Y., B.R., J.W., M.A. and B.J.G. The circumstances are as follows:

A. Respondent's records for S.G. falsely indicate the patient refused a transfusion for the December 1996, surgery during which she lost a lot

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of blood. Prior to her December 1996, patient S.G. went to the Red Cross to give blood in case she needed it during her surgery. In truth, respondent never discussed the subject of a transfusion with S.G.

B. Respondent attempted to scare S.G. into agreeing to undergo surgery by telling her she would "burst and bleed to death" if she did not have the surgery respondent recommended.

C. Respondent refused to take telephone calls from S.G. during the time the patient was receiving hormone replacement.

D. Respondent told D.M-G. she had a tumor on each of her ovaries that could become cancerous, despite the fact there is no evidence that such tumors existed.

E. Respondent told D.M-G. the only way her insurance company would pay for bladder surgery was if she had a hysterectomy, which she agreed to have in October 1997.

F. Respondent attempted to scare L.M. into having surgery by telling her that the problem with her cervix could turn into cancer in 5 weeks. When she told respondent she wanted a second opinion he expressed the hope she had enough time. The problem with L.M.'s cervix is often left untreated by Ob-Gyns without dire consequences.

G. In January 2000, respondent told L.M. she needed immediate surgery to remove a right ovarian tumor. Although a cancer specialist, Dr. M., did not see any tumor and offered to due an ultrasound within the week, respondent scared L.M. into having the surgery immediately.

H. Respondent told patient M.P. she could bleed out if she did not have the recommended surgery right away.

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I. Respondent attempted to scare A.Y. into having the surgery recommended by respondent by telling her she would be unable to have children with endometriosis, going so far as to recommend she have children out of wedlock.

J. Respondent attempted to scare B.R. into having the surgery recommended by respondent by telling her the condition would turn into cancer and that if she did not have the surgery right away it may be too late.

K. Respondent scared J.W. into having the major surgery by lying about the true nature of her condition.

L. Respondent scared M.A. into having the major surgery by lying about the true nature of her condition.

M. Respondent lied to the patient about the extent of her endometriosis, as the path report showed a minimal to mild case, not an infestation as described by post operatively by respondent.

N. Respondent scared the patient into having the major surgery by lying about the true nature of her condition.

NINTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Records)

37. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate records during his care and treatment of the following patients: D.M-G., L.M., J.S.M., M.P., J.L.M., B.R., J.W., M.A., B.J.G., and V.G. The circumstances are as follows:

A. Paragraph 19 (A) through (EEEE) is hereby incorporated by reference as if fully set forth.

B. It is impossible to determine the degree to which D.M-G. had pelvic relaxation from the paucity of respondent's clinic note.

C. From the December 15, 1998, sonogram performed on L.M. there are six unlabeled images.

D. From the sonogram of April 7, 1999, performed on L.M. there are four unlabeled images, and the assessment and plan are illegible.

E. From the January 6, 2000, sonogram performed on L.M. there are six unlabeled images.

F. Following J.S.M.'s visit on August 29, 1996, an office sonogram was performed. There are two unlabeled printouts, and no printouts which document the findings of "left ovary tender mass 5x5 cm, right is abnormal."

G. From the August 7, 1995, sonogram performed on patient M.P. there are four unlabeled images.

H. There is no documentation of the physical exam respondent performed on J.L.M. on April 12, 1999, nor are the results of the CBC drawn April 12, 1999, contained in the record.

I. Respondent's colposcopic examination note of B.R. failed to mention whether, and to what extent, lesions could be seen. The documentation fails to allows for appropriate decision making as result of the colposcopy.

J. Respondent's history and work-up of J.W.'s chronic pelvic pain and dysparuenia were inadequate.

K. Respondent's work-up of B.J.G.'s urinary complaint was inadequate.

L. Respondent's work-up of the V.G.'s urine loss was inadequate.

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TENTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

38. Respondent is subject to disciplinary action under section 2234 of the Code in that he committed general unprofessional conduct during his care and treatment of the following patients: S.G., D.M-G., L.M., M.P., A.Y., B.R., J.W., M.A., and B.J.G., The circumstances are as follows:

A. Paragraph 19 (A) through (EEEE) is incorporated by reference herein as if fully set forth.

B. Respondent attempted to scare S.G. into agreeing to undergo surgery by telling her she would "burst and bleed to death" if she did not have the surgery respondent recommended.

C. Respondent refused to take telephone calls from S.G. during the time the patient was receiving hormone replacement.

D. Respondent told D.M-G. she had a tumor on each of her ovaries that could become cancerous despite the fact there is no evidence that such tumors existed.

E. Respondent told D.M-G. the only way her insurance company would pay for bladder surgery was if she had a hysterectomy, which agreed to have in October 1997.

F. Respondent told L.M. that the problem with her cervix could turn into cancer in 5 weeks. When she told respondent she wanted a second opinion he expressed the hope she had enough time. The problem with L.M.'s cervix is often left untreated by Ob-Gyns without dire consequences.

G. In January 2000, respondent told L.M. she needed immediate surgery to remove a right ovarian tumor. Although a cancer specialist, Dr. M., did not see any tumor and offered to due an ultrasound within the week, respondent scared L.M. into having the surgery immediately.

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H. Respondent told patient M.P. she could bleed out if she did not have the recommended surgery right away.

I. Respondent attempted to scare A.Y. into having the surgery recommended by respondent by telling her she would be unable to have children with endometriosis, going so far as to recommend she have children out of wedlock.

J. Respondent attempted to scare B.R. into having the surgery recommended by respondent by telling her the condition would turn into cancer and that if she did not have the surgery right away it may be too late.

K. Respondent scared J.W. into having the major surgery by lying about the true nature of her condition.

L. Respondent scared M.A. into having the major surgery by lying about the true nature of her condition.

M. Respondent lied to B.J.G. about the extent of he endometriosis, as the path report showed a minimal to mild case, not an infestation as described by post operatively by respondent.

N. Respondent scared B.J.G. into having the major surgery by lying about the true nature of her condition.

ELEVENTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

39. Respondent is subject to disciplinary action under section 725 of the Code in that he excessively prescribed medication to J.L.M. during his care and treatment of her. The circumstances are as follows:

A. Paragraph 19 (WW) through (ZZ) is hereby incorporated by reference as if fully set forth.

B. Between April 19 and October 4, 1999, respondent prescribed J.L.M. 386 Vicodin tablets, in addition to prescribing her Phentermine in September.

TWELFTH CAUSE FOR DISCIPLINE

(Sex With a Patient)

40. Respondent is subject to disciplinary action under section 726 of the Code in that he had sexual relations with V.G. at a time when she was his patient. Paragraph 19 (AAAA) through (EEEE) is incorporated by reference as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division of Medical Quality issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. G 24947, issues to Andrew Rutland, M.D.;

2. Revoking, suspending, or denying approval of Andrew Rutland, M.D.'s authority to supervise physician's assistants, pursuant to section 3527 of the Code;

3. Ordering respondent Andrew Rutland, M.D. to pay the Division of Medical Quality the reasonable costs of the investigation and enforcement of this case, and, if placed on probation, the costs of probation monitoring;

4. Taking such other and further action as deemed necessary and proper.

DATED: June 28, 2002

RON JOSEPH
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

03573160-SD2001AD0247; Second Amended Accusation
SHZ:pll

EXHIBIT B
INTERIM SUSPENSION ORDER

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BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the *Exparte* Petition for Interim Order Against: ANDREW RUTLAND, M.D. 7495 Hummingbird Circle Anaheim Hills, CA 90807 Physician's and Surgeon's Certificate No. G 24947 Physician Assistant Supervisor License Number SA 18870, Respondent.	OAH NO. L-2002070042 CASE Nos. 18-2002-13467(JW); 18-2002-134903(Med. Rec. #365409); 18-2002-134650(BJG); 18-2002-134651(VG); 18-2002-134646(MA)

EXPARTE INTERIM SUSPENSION ORDER

This *Exparte* matter was heard by Roy W. Hewitt, Administrative Law Judge ("ALJ"), Medical Quality Hearing Panel, Office of Administrative Hearings, at Los Angeles, California on July 3, 2002.

Deputy Attorney General Steven H. Zeigen represented petitioner.

Respondent, Andrew Rutland, M.D., personally appeared and was represented by Peter R. Osinoff, Esq.

Documentary evidence was received, the parties orally argued their respective positions, and the matter was submitted.

FACTUAL FINDINGS

Having read and considered the Petition for Interim Order, the supporting memorandum of points and authorities, declarations and exhibits, and having read and considered any opposition papers filed thereto, and having heard arguments by counsel for the parties, the ALJ makes the following Factual Findings and Legal Conclusions:

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1. The affidavits in support of the Petition for Interim Order show:

1) Respondent, Andrew Rutland, M.D,. has engaged in, and continues to engage in, acts and omissions that violate the Medical Practice Act, and;

2) Permitting respondent to continue practicing medicine has, and will continue, to endanger the public health, safety and welfare, and;

3) It appears from the facts shown by the affidavits that serious injury would result to the public before the matter can be heard on notice.

2. Respondent, joined by his attorney, waived the time restraints, notice and service requirements of Government Code section 11529, subdivision (c), and stipulated to having the hearing on interim order on August 27, 2002 at 1:30 p.m. Respondent and his attorney further stipulated to receiving service of this order by regular mail. The waivers and stipulations were placed on the record.

ORDER

WHEREFORE, THE FOLLOWING ORDER, in conformity with California Government Code section 11529, subdivisions (a) and (b), is hereby made:

Respondent Andrew Rutland's Physician's and Surgeon's Certificate No. G 24947, issued to respondent on July 9, 1973, and respondent's Physician Assistant Supervisor Approval No. SA 18870, are immediately suspended. Consequently, effective immediately, respondent Andrew Rutland, M.D. shall not practice medicine, or supervise physician's assistants in the State of California.

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IT IS FURTHER ORDERED, in conformity with Government Code section 11529, subdivision (c), that:

A hearing on the Petition for Interim Order, pursuant to California Government Code section 11529, subdivision (d), shall be held at the Office of Administrative Hearings, 320 West Fourth Street, 6th Floor, Suite 630 (Hearing room to be assigned), Los Angeles, California 90013 (tel. 213-576-7200), on August 27, 2002, at 1:30 p.m., or as soon thereafter as the matter can be heard.

Dated: July 3, 2002.

ROY W. HEWITT
Administrative Law Judge
Office of Administrative Hearings